STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 89011-001**

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 7, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901, *et seq.* The Commissioner reviewed the request and accepted it on April 14, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 22, 2008.

The Petitioner's group health care coverage is defined by the BCBSM *Community Blue Group Benefits Certificate* (the certificate). The issue in this external review can be decided by an analysis of this contract. The Commissioner reviews contractual issues pursuant to section 11(7) of the PRIRA, MCL 550.1911(7). This matter does not require a medical review by an independent review organization.

II
FACTUAL BACKGROUND

On December 4, 2007, the Petitioner had back surgery at XXXXX provided by XXXXX, a nonparticipating provider with BCBSM. The surgeon charged $15,839.54 and BCBSM paid $4,422.97, leaving the Petitioner to pay the $11,416.57 balance.

The Petitioner appealed the amount BCBSM paid. BCBSM held a managerial-level conference on March 3, 2008, and issued a final adverse determination dated March 11, 2008. The Petitioner exhausted BCBSM's internal grievance process and seeks review by the Commissioner under PRIRA.

III
ISSUE

Is BCBSM required to pay more for the Petitioner's December 4, 2007, surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner indicates that he got no information from the surgeon, his office staff, or XXXXX that there would be a problem with the amount paid by BCBSM for the surgery. Before the surgery, BCBSM paid directly for several appointments. For two appointments BCBSM paid the Petitioner directly and he then sent the check to the doctor. He says he received no billings from the provider for any of this care.

The Petitioner also says he was not informed by BCBSM that his surgeon was not participating. It was not until the surgery was scheduled that the Petitioner was informed by the surgeon's office that he might be required to pay $2,000.00 to $3,000.00 out of his own pocket. The Petitioner had no idea that he would be required to pay close to $12,000.00 for his care.

The Petitioner believes that BCBSM level of payment for his surgery is too low for such high-skilled, high-risk procedures and it should be required to pay significantly more.

BCBSM's Argument

The Petitioner's coverage provides that BCBSM will pay its approved amount for the Petitioner's December 4, 2007, surgery. However, since XXXXX does not participate with BCBSM,

he is not obligated to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between his charge and BCBSM's approved amount.

The following table sets forth the amounts charged by the provider and the amounts paid by BCBSM:

Procedure Code	Amount Charged	Maximum Payment Amount	Amount Paid by BCBSM	Balance Due
63075	$5,674.50	$2,077.63	$2,077.63	$3,596.87
22554	$5,132.50	$1,962.11	$981.05*	$4,151.45
22845	$4,530.04	$1,184.66	$1,184.66	$3,345.38
20931	$502.50	$179.63	$179.63	$322.87
Total	$15,839.54		$4,422.97	$11,426.57

BCBSM says it is not obligated to pay more than the approved amount even in emergency situations, or when the patient has no choice of providers, or even if the Petitioner was referred by a participating provider.

Moreover, because XXXX performed multiple surgeries on the same day, Section 4 (page 4.3) of the certificate also applies:

> Multiple surgeries provided on the same day by the same physician are paid according to national standards recognized by BCBSM.

BCBSM said its medical staff reviewed the documentation but did not find any indication that the Petitioner's surgery was more complex than usual for his condition that would warrant additional payment. There is no assertion by the Petitioner that his surgery was other than as described in the procedure codes billed byXXXXX.

BCBSM believes that it paid its approved amount for the surgical services received by the Petitioner.

Commissioner's Review

The certificate describes how benefits are paid. On page 4.2, the certificate says that BCBSM pays its "approved amount" for physician and other professional services. The approved

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* BCBSM paid 50% of its maximum payment level based on the national standard that pays 100% of the maximum payment amount for the primary procedure and 50% of the maximum amount for secondary procedures.

amount is defined on page 7.2 as "the lower of the billed charge or [BCBSM's] maximum payment level for the covered service."

The approved amount is paid to both participating and nonparticipating providers. BCBSM's participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full. In Section 4 of the certificate, "How Physician and Other Professional Provider Services Are Paid," the Petitioner is cautioned about this (page 4.27):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate also indicates that multiple surgeries performed by the same surgeon on the same day are paid according to national standards. In this case, BCBSM paid the full maximum amount for the primary procedure and 50% of the maximum amount for the secondary procedure Therefore, BCBSM paid its maximum approved amount for the Petitioner's December 4, 2007, surgery.

The Petitioner indicates he did not receive proper notice that he would be responsible for the balance of his surgery. However, certificate language is clear that it is the Petitioner's responsibility to determine if the provider participates with BCBSM. It is unfortunate that the Petitioner could not or did not use a participating surgeon. Nevertheless, the certificate does not require BCBSM to pay more than its approved amount for services of a nonparticipating provider in such a situation, even if there was no choice of providers or even if the Petitioner is referred to the nonparticipating provider by a participating provider.

The Commissioner finds that BCBSM has paid the claim correctly according to the terms and conditions of the certificate and is not required to pay more for the services provided to the Petitioner.

V
ORDER

BCBSM's final adverse determination of March 11, 2008 is upheld. BCBSM is not required to pay more for the Petitioner's surgery provided on December 4, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Ken Ross
Commissioner